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Committee on Energy and Commerce  
Subcommittee on Health

Hearing on the Protect Life Act

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Mr. Chairman and Distinguished Members of this Subcommittee:

Thank you for the opportunity to appear before you today to present remarks on the Protect Life Act (H.R. 538)

In revising the Patient Protection and Affordable Care Act, the proposed legislation would make far-reaching changes.

- Despite the fact that the ACA is absolutely clear that federal funds may not be used to pay for or provide abortions, the bill would reach beyond the furthest limits of Hyde Amendment and directly into the Internal Revenue Code. It would do so by amending the ACA to bar abortions in tax-favored products (including multi-state products). Specifically, the bill would bar the use of advance premium tax credits or cost-sharing reductions for health plans that cover abortions other than certain specified procedures, even if the additional medical cost protections are paid for privately. Furthermore, the law proposes a solution to restructuring private health insurance products that not only would eliminate access to coverage but could further compromise women's access to medically necessary health care.
- In response to claims that existing conscience laws are somehow lacking, the bill would amend the ACA to essentially reiterate current legal protections, a pretext for an additional amendment that would create an unprecedented federal private right to sue federal, state, and local governments for perceived violations. In adding a new private right of action barring discrimination by federal agencies and programs and federally assisted state and local governments, the bill would establish no similar privately enforceable protections for entities that are discriminated against because they provide legal abortions.
- The bill would preempt state anti-discrimination laws that protect entities that provide or pay for abortions, while saving from preemption only those state laws that protect conscience rights, restrict or prohibit abortion or abortion funding, or impose limitations on access to legal abortions.
- In creating new conscience rights under the ACA, the bill would fundamentally threaten women's right to emergency screening and stabilization treatment from Medicare-participating hospitals under the Emergency Medical Treatment and Labor Act (EMTALA)

**The Bill's Revision to the ACA's Premium Tax Credit Policies Would Have Far-Reaching Effects on Health Insurance and Women's Access to Medically Necessary Health Care**

The Protect Life Act would exclude the sale of health plan products that cover and pay for prohibited abortions, even if the additional coverage is paid for with private funds. Health plans, whose terms of coverage and payment reach excluded procedures, even if medically indicated, would not qualify for either refundable tax credits or cost-

sharing assistance. In other words, the amendments would upend the compromise reached prior to final passage.

Such an amendment would have a far-reaching impact. Although it would permit a supplemental coverage market if premiums are paid for with non-federal funds, the bill bars supplemental coverage whose administration is not entirely supported out of supplemental payments. This condition can be expected to lead to the complete exodus of abortion coverage from the affected market, help move the entire health insurance market away from coverage of barred procedures, and trigger dangerous spillover effects on women's access to health care.<sup>1</sup>

*The ban contained in the Protect Life Act, when combined with the tax reforms contained in H.R. 3, No Taxpayer Funding for Abortion Act, will produce an industry-wide impact that will shift the standard of coverage for medically indicated abortions for all women.* In view of how the health benefit services industry operates and how insurance product design responds to broad regulatory intervention aimed at reshaping product content, the coverage exclusions imposed can be expected to have an industry-wide impact, eliminating coverage of medically indicated abortions over time for all women, not only those whose coverage is derived through a health insurance exchange. As a result, this bill, particularly when combined with H.R. 3, can be expected to propel the industry away from current norms of coverage for medically indicated abortions. In combination with H.R. 3 and existing Hyde Amendment provisions applicable to Medicaid and other federal programs (including the federal employee health benefits program), the Protect Life Act will lead insurers to recalibrate product design away from any abortion coverage across the board, in order to accommodate the ban on products.

*The supplemental insurance coverage provisions are unworkable and the bill carries enormous implications for women's access to medically necessary health care.* The provisions of this bill will, by their very terms, defeat the development of a supplemental coverage market for medically indicated abortions. In any supplemental coverage arrangement, it is essential that the supplemental coverage be administered in conjunction with basic coverage. This intertwined administration approach is barred under this measure, because it prohibits comingling of funds for plan administration. The bar against commingling poses particular challenges in cases in which an underlying health condition necessitates the need for abortion, as well as in cases in which a medically indicated abortion leads to complications. Entirely separate networks, utilization management, and coverage determination procedures would be required. Furthermore, in situations in which the presence of an underlying condition (such as cancer) compels the need for an abortion, or where the abortion leads to further complications of a condition, the basic insurance plan can be expected to bar payment for such follow-on treatments on the grounds that they are related to a prohibited procedure.

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<sup>1</sup> S. Rosenbaum, L. Cartwright-Smith, R. Margulies, S. Wood, and D. Mauery, *An Analysis of the Implications of the Stupak/Pitts Amendment for Coverage of Medically Indicated Abortions* (George Washington University School of Public Health and Health Services, Department of Health Policy, 2009) [http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp\\_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=FED314C4-5056-9D20-3DBE77EF6ABF0FED](http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/index.cfm?mdl=pubSearch&evt=view&PublicationID=FED314C4-5056-9D20-3DBE77EF6ABF0FED).

It is customary for plans to exclude such follow-on treatment where the precipitating event for the treatment is an excluded procedure.<sup>2</sup>

### **The Bill Would Preempt State Non-Discrimination Laws Aimed at Protecting Health Care Entities that Furnish Lawful Abortions**

In preempting state nondiscrimination laws aimed at protecting plans and entities that pay for or provide abortions, the bill would usurp state powers to regulate their health care and health insurance markets by protecting health care entities engaged in lawful conduct. In a complete departure from principles of federalism in health care, the bill would preempt state laws that prohibit health plans from denying network membership to physicians who perform lawful abortions, or that prohibit plans from denying network status to hospitals that perform abortions in medically indicated cases, including those in which an emergency medical condition is present.

### **The Bill Would Create Enormous Liability Exposure in Federal and State Governments, While Recognizing Only Certain Types of Discriminatory Treatment**

Despite the sweep of existing laws, including the Church Amendments, the Weldon Amendment, and the Coats Amendment,<sup>3</sup> proponents of this measure struggle to identify loopholes<sup>4</sup> and assert that codification within the ACA is essential. The bill

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<sup>2</sup> See, e.g. *Kenseth v Dean Health Plan*, 610 F. 3d 1652, (7<sup>th</sup> Cir. 2010), involving the authority of health plans to deny provision of otherwise covered procedures needed to address complications arising out of excluded treatments.

<sup>3</sup> The Church Amendments, part of U.S. law since the 1970s, make clear that the receipt of federal funds does not require an individual or institution to provide sterilization or abortion services and permit individuals to refuse to participate in such procedures if doing so would contravene religious or moral convictions. 42 U.S.C. §300a-7 (2008). The Coats Amendment, enacted in 1996, prohibits the federal government or any state or local government receiving federal financial assistance from “discriminating” against any physician, residency training program, or participant in a health professions training program on the ground that the person or entity refuses to receive or provide training in induced abortions, to perform such abortions, or provide referrals for such training or abortion. 42 U.S.C. §238n (2008) The Weldon Amendment, originally enacted in 2004 as part of the Labor-HHS appropriations bill and included in subsequent appropriations, provides that no funds made available in the bill can go to an agency or program or to a state or local government, “if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortion.” Consolidated Appropriations Act, 2008, Pub. L. No. 110-161, §508(d), 121 Stat. 1844, 2209 (2007).

<sup>4</sup> See, e.g., United States Conference of Catholic Bishops, *Legal Analysis of the Provisions of the Patient Protection and Affordable Care Act and Corresponding Executive Order Regarding Abortion Funding and Conscience Protection* (undated). The memorandum identifies the points at which the ACA bars direct funding of abortions ((PPACA §4101 related to school health services, PPACA §1303(b) (2), barring the use of premium credits and cost sharing reductions to pay for abortions). The memo also concedes that the Conference itself is unclear as to whether existing laws, coupled with provisions of the Act are sufficient to assure that federal funds are not used to provide or pay for abortions. (“Given the length and complexity of the Act, we cannot exclude the possibility that the PPACA contains other particular exclusions of abortion funding in areas where that funding might otherwise be mandated. But this uncertainty only underscores the need to have a prohibition on such funding that covers the entire Act.” Memorandum, note 3.) See, also, Helen Alvaré, *How the New Health Care Law Endangers Conscience*, *Public Discourse: Ethics, Law and the Common Good* (June 29, 2010), which in arguing for expansion of conscience clause protections

accordingly reiterates existing laws in the ACA itself, with a few relatively minor modifications.<sup>5</sup> But the real agenda here is visible in the bill's additional amendment to create an unprecedented, federal private right of action.<sup>6</sup> Furthermore, the bill would extend no similar private enforcement rights to entities that allege discrimination by the federal, state or local governments because they provide lawful abortions.

The extent to which the assertions that existing conscience laws are weak is merely a pretext for the creation of a federal right to sue the government becomes clear when modern jurisprudence doctrines governing private rights of action are considered. Under binding United States Supreme Court precedent, the right of private parties to sue to enforce federal laws cannot be implied.<sup>7</sup> Furthermore, at least one federal Court of Appeals has in recent years expressly applied this precedent to conscience clause claims and has expressly rejected the argument that a private right of action can be implied under federal civil rights doctrine.<sup>8</sup> Thus, proponents of conscience clause litigation need an express right of action to bring lawsuits, a right that cannot be granted in regulation and must be granted by Congress. Crafting such a right to sue makes sense only if there is an underlying right to which the right to sue is attached. Hence the strong assertions that somehow existing laws inadequately protect conscience, in order to bootstrap rights – and litigation rights – into the law.

Put simply, the claims that the ACA does not sufficiently protect conscience are inextricably intertwined with advocacy for the legislative establishment of (restated) conscience clause rights, along with a right to sue state, local, and federal governments. Moreover, the new provision is itself discriminatory. Only covered entities that refuse to engage in certain types of activities would possess such a right or be granted a federal right of action. Entities that experience discrimination because of their willingness to engage in lawful abortion practice and coverage would be given no such rights.

The new private right of action would empower the federal courts to reach both “actual” and “threatened” (both terms are undefined) violations of the new conscience

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also concedes the reach of numerous safeguards contained in the law, including §1303(b)(1) (barring the term essential health benefits from being interpreted to include abortion procedures), §1304(b)(4) (prohibiting qualified health plans from discriminating against any health care provider or facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions), §1553 (protecting conscientious objectors), the law's safeguards. Neither advocate of additional restrictions can identify instances in which the existing Presidential Executive Order related to community health centers and abortion funding has been ineffective. Nor do advocates argue that the July 2010 federal prohibition on the use of pre-existing condition plan funds to pay for abortions has been incomplete.

<sup>5</sup> In the case of Weldon, the bill would add “participate in,” to the types of conscience-related conduct protected under the non-discrimination provision. In the case of Coats, the measure would slightly reword the existing law while expanding the meaning of “health care entity” protected under the law.

<sup>6</sup> Protect Life Act, §1303 as amended.

<sup>7</sup> *Alexander v Sandoval*, 532 U.S. 275 (2001). See, Sara Rosenbaum and Joel Teitelbaum, Civil Rights Enforcement in the Modern Healthcare System: Reinvigorating the Role of the Federal Government in the Aftermath of *Alexander v Sandoval*,” *Yale Journal of Health Law and Policy* (Spring 2003).

<sup>8</sup> *Cenzon-DeCarlo v Mount Sinai Hospital*, 626 F. 3d 695 (2d Cir. 2010).

clause right, and courts would be further empowered to issue “any form of legal or equitable relief,” presumably including compensatory and punitive damages. A broadened range of health care entities would have the right to bring such suits, including an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.<sup>9</sup>

### **The Bill Could Have a Deleterious Effect on Women’s Right to EMTALA Protections in the Case of Health and Life-Endangering Conditions**

The Emergency Treatment and Labor Act (EMTALA)<sup>10</sup> represents perhaps the most important health care access law ever enacted in the U.S. Applicable to all Medicare-participating hospitals with emergency departments, the law establishes three basic obligations on the part of covered hospitals: to screen persons who come to the emergency department and on whose behalf a request for an examination is made, in order to identify the existence of an “emergency medical condition;” to stabilize emergency medical conditions in the case of persons who are patients of a hospital; and in the case of patients whose conditions cannot be stabilized, to undertake a medically appropriate transfer to a hospital with the capability to do so and that has agreed to accept the patient.<sup>11</sup> EMTALA defines the term “emergency medical condition” as

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in— (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions— (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.<sup>12</sup>

EMTALA was drafted with preserving the health of pregnant women and their infants as a front and center aim; the statute has existed alongside the Hyde Amendment for 25 years and stands as a singular testament to the notion that no individual with a health emergency should be denied care.

In creating a new federal “right” of conscience, the bill threatens to fundamentally undermine EMTALA enforcement against hospitals that refuse to respond to emergency medical conditions involving pregnant women. Furthermore, in creating a federal right of action against the federal government to halt “actual or threatened” acts of “discrimination,” the bill raises the specter of preemptive strikes by hospitals claiming

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<sup>9</sup> §1303(g)(2) as added.

<sup>10</sup> 42 U.S.C. §1395dd.

<sup>11</sup> Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY, 1997). Ch. 1. See also 2010 manuscript, Sara Rosenbaum, David Frankford, Sylvia Law and Rand Rosenblatt, *Law and the American Health Care System*, reviewing revisions to EMTALA and more recent cases.

<sup>12</sup> 42 U.S.C. §1395dd(e)(1) (2008).

the right to withhold life-saving screening and stabilization treatment, or even the right to refuse to transfer a patient whose emergency medical condition signals the need for an abortion. Virtually any hospital that claims coverage under the new right of action could sue to enjoin the federal government from enforcing its EMTALA duties.

EMTALA has withstood enormous pressure over the years because of Congress' belief in the absolute importance of abiding by its core obligations on the part of a hospital industry that in 2010 accounted for one-third of the program's \$509 billion in expenditures.<sup>13</sup> Indeed, so important are EMTALA's protections that at least one court has applied its requirements in a case involving an infant for whom treatment was judged medically futile, concluding that EMTALA's principles sufficiently powerful to override competing medical considerations.<sup>14</sup> To permit an amendment that strikes at these core principles would open EMTALA to against attack by those who would allow hospital emergency departments to make choices about who lives or dies and who is worthy of emergency medical care.

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<sup>13</sup> Kaiser Family Foundation, *Medicare at a Glance* (2010) <http://www.kff.org/medicare/upload/1066-13.pdf> (Accessed Feb. 7, 2011)

<sup>14</sup> *In the Matter of Baby K*, 16 F. 3d 590 (4<sup>th</sup> Cir. 1994).